

Introduction

Annals News and Perspective explores topics relevant to emergency medicine, in particular those in which our specialty interacts with the political, ethical, sociologic, legal and business spheres of our society. Discussion of specific clinical problems and their

management will be rare. By design, it will not be a “breaking news” section with the latest (and undigested) developments, but instead a reflective investigation of recent and emerging trends. If you have any feedback about this section, please forward it to us at annalsnews@acep.org.

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HIV TESTING: SHOULD THE EMERGENCY DEPARTMENT TAKE PART?

Maryn McKenna

Special Contributor to Annals News and Perspective

In a marked move from current practice—a change that has been more than a decade in the making but nevertheless feels abrupt to many—emergency departments (EDs) are being strongly encouraged to test all adolescent and adult patients for HIV infection.

The change in policy, embodied in a set of recommendations issued September 21, 2006 by the United States Centers for Disease Control and Prevention (CDC), flows from a long-standing frustration. Twenty-five years into the HIV/AIDS epidemic, the United States continues to gain approximately 40,000 new cases of HIV infection a year, and yet it is still impossible to state the true US incidence because an estimated one-fourth of those believed to be infected have never been tested.

That lack of knowledge breeds a host of negative outcomes. It prevents those who are infected from entering treatment before serious immunologic damage occurs: approximately 40% of those who test positive for HIV in the US develop AIDS in less than a year. Simultaneously, it prevents them from taking measures to avoid transmitting the virus: up to 20,000 new infections each year may be caused by those unaware of their status, according to the CDC.

A MISSED OPPORTUNITY

Making matters worse, according to the public health agency, is that many of those unaware of their infection could have been enlightened. They had some routine encounter with the health care system between when they were infected and when they were diagnosed but were not offered an HIV test and did not think to ask for one.

That lack of attention to undetected HIV infection occurred despite previous CDC recommendations, in existence since 1993. They called for routine testing for

anyone who appeared to be at high risk or in any area where HIV prevalence is greater than 1% of the population—a measure that one CDC scientist wryly calls “the most widely ignored recommendation the CDC has ever made.”

“The strategy of targeting high-risk individuals worked relatively well,” said that scientist, Bernard Branson, MD, associate director for laboratory diagnostics at the National Center for HIV, STD and TB Prevention, and a co-author of the new recommendations. “But the people who remained undiagnosed were people who didn’t perceive that they were at risk, and so we needed a different strategy to reach them.”

The new strategy—routine testing in all health care settings of every patient between the ages of 13 and 64—was prefigured by the Institute of Medicine’s 1999 proposal that HIV testing be offered routinely to all pregnant women, a measure that became CDC policy in 2003. The consultations that led to the 2003 recommendation revealed widespread dissatisfaction with the long-standing structure in which HIV testing was offered: lengthy pretest and posttest counseling that included written informed consent. IOM analyses, CDC meetings, and a growing chorus in the medical literature all delivered the same opinion: the era of “AIDS exceptionalism” should come to an end.

A GROWING CHORUS FOR CHANGE

Over the past 2 years, analyses in the *British Medical Journal*, *American Journal of Public Health* and *New England Journal of Medicine* made versions of the same essential points: the process by which HIV tests are performed no longer matches the reality of the disease. Once, the authors said, the implications of an HIV test rivaled in seriousness those attached to tests for genetic disabilities. Like genetic testing, a positive HIV test carried not only dire health consequences but the possibility of family disruption, loss of

insurance and social stigma as well. With the advent of highly active antiretroviral therapy, they argued, HIV tests have become more like tests for tuberculosis, a condition that though grave is manageable—and that threatens the public health if it is not discovered.

Armed with those arguments—and with the HIV oral-fluid rapid tests that became available in 2004—the CDC began examining whether to institute HIV testing throughout health care, and de-emphasized the highly structured counseling process to make that feasible. The increasing use of EDs as a substitute for primary care made them a logical place to conduct testing. But studies dating back to 1996—when the recommendation to test high-risk patients was in force—found that only 51% of departments tested those who seemed at high risk, and only 3% tested those suspected of having other sexually transmitted diseases.

THE DEBATE ABOUT ED TESTING

Yet because EDs see such heavy use by groups who have no other contact with health care—including the underserved and uninsured who are among HIV's new risk groups—some emergency physicians argue that the ED is the site where testing is most needed.

“Emergency medicine has a significant, though unstated, public health role,” said Atlanta physician Barry Baker, MD. “We are the face of medicine for people who do not have access to continuity of care.”

Baker has an intimate understanding of the arguments for and against testing in EDs. He is an emergency physician but left practice more than a decade ago after discovering he is HIV-positive and now works as a non-clinical consultant.

“We would all acknowledge that emergency departments are in many cases overwhelmed,” he said. “There is always a dynamic tension between trying to provide care for everybody and deciding what can be deferred or referred out. I think, before, there was not an expectation that emergency departments should do this. But now it is setting a standard, that we should take this on as a professional, even a moral obligation.”

THE COUNSELING BACKLASH

The CDC released the recommendations to health professional organizations in draft form in March 2006, hoping for comment. And many responses—not all of them positive—came back.

Organizations whose members advocate or care for AIDS patients and those infected with HIV applauded the underlying goal of increasing the number of HIV-positive individuals who know their serologic status. And they agreed that health care settings, especially EDs, were an appropriate place for that knowledge to be obtained. But they objected, sometimes at length, to the changes in the painstaking process of counseling and referral that the CDC was willing to make to reach that goal.

The American Academy of HIV Medicine said that making testing the default approach when the patient doesn't specifically refuse—a complete reversal from the longstanding process of conscientious and lengthy pretest counseling—would swiftly morph, in practice, into a failure to offer the opt-out option. The American Bar Association warned that a diagnosis of HIV infection and even more of active AIDS still carries a risk of stigma and worried that the foreshortened counseling process would no longer include referrals to legal services. Fifty-four AIDS service organizations wrote to caution that prevention advice, once a mainstay of pre- and post-test counseling even for those found negative, would be skimmed.

Overwhelmingly, the critics objected to the abandonment of separate, written informed consent to testing—exactly the “exceptionalism” that those in favor of the change had criticized—and voiced strong concern that the streamlined process would no longer link the newly diagnosed to follow-up care.

“The HIV-AIDS advocacy community has consistently emphasized the relationship of counseling and testing to the possibility of discrimination, and also of empowerment,” said Melanie Sovine, PhD, executive director of the AIDS Survival Project in Atlanta, one of the oldest US AIDS service organizations. “Any policy that suggests you are just testing someone and just giving them a piece of information without support is not going to be well-received by this community. It risks decoupling testing from the ethical issues that flow from it.”

Lack of access to follow-up treatment is a common problem for ED patients with serious diagnoses. In a 2005 study, researchers who represented themselves as patients needing urgent follow-up care after an ED visit—for pneumonia, hypertension or possible ectopic pregnancy—faced grave difficulties obtaining appointments even if they claimed to have private insurance or to be willing to pay cash.

ACEP STUDYING THE ISSUE

So far, the American College of Emergency Physicians has not issued a policy on the CDC recommendations, though a committee of the College is studying the implications. Richard Rothman, MD, PhD, of Johns Hopkins University's Department of Emergency Medicine—who published a 2004 analysis in this journal of emergency physicians' “critical role” in HIV testing—is on the committee and said concerns run from practical issues to legal ones.

“The most immediate and obvious [issue] is that without some additional resources and infrastructure—and that includes both dollars and manpower—the idea of routinely screening every single person who comes into the emergency department is not doable today,” he said. “But I think there is also a recognition that there are a variety of ways these guidelines may be actualized, and that individual EDs and individual municipalities and states will have to develop their

own set of practical responses to the guidelines. It may not be a one size fits all.”

Two early studies illustrated the potential of ED-based testing. In one, staff at an urban urgent care clinic in Atlanta offered routine testing to all adult patients over a 24-week period in 2000; twice as many were found to be HIV-positive compared to a 24-week period a year earlier when staff recommended the test only to patients who seemed high risk. In another, the state of Massachusetts in 2002 began offering routine testing in four urgent care centers; at the end of the first year, 2% of the patients who had not previously known their status but had agreed to be tested were found to be positive.

Those studies also illustrate the pitfalls of testing in a health care setting. In the Atlanta study, only 40% of those offered testing accepted it, 72% of those who accepted it were actually tested, and 26% of those who were tested never received their results. In the Massachusetts study, though 2% of those who accepted testing were found to be positive, only 82% of that 2%—49 out of 60—returned to get their test results, and only 70%—42 out of 60—entered follow-up care. Getting them to collect their results and enter follow-up care, according to the Massachusetts Department of Public Health, took a minimum of 4 phone calls plus a follow-up letter, and in some cases distributing bus vouchers and tracking down test recipients via homeless shelters.

THE PROMISE AND THE PITFALLS

Several demonstration projects funded by the CDC over the past several years illustrate both the promise of ED-based testing and the effort required to make it successful. At the John H. Stroger, Jr. Hospital of the Cook County Bureau of Health in Chicago, Eileen Couture, DO, RN, offered routine testing for 31 months to all comers in the ED, uncovering an unsuspected prevalence of 2.5%—including some who had no known risk factors and who came to the ED for completely unrelated problems such as neck pain and a diabetic crisis.

The tests were offered and conducted by 3 health educators hired with grant funds; positive patients were referred to a “core center” shared among several hospitals and funded by Cook County.

“Before you start any testing, you have to have follow-up arranged,” said Couture, who is now clinical chair of the ED at Oak Forest Hospital, a sister institution to Stroger.

In Oakland, CA, CDC grantee Douglas White, MD, built on Couture’s study by pinning a routine testing project entirely on his ED’s existing staff, an effort that leaned heavily on nurses to educate patients, perform tests and deliver negative results and relied on physicians to break the

news that patients were positive and link them to follow-up care. The project at Highland Hospital at Alameda County Medical Center, which began in early 2005, found a prevalence rate of 1%—lower than other such programs—but reports a follow-up care rate of 94%, achieved through multiple phone calls.

The project succeeded, White said, through aggressive paring down of the traditional counseling regime; both pretest counseling and posttest harm reduction messages for those who are negative are delivered by brochure. Key to its success, he said, was strong support by the nursing staff. They believe “it is a valuable intervention,” he said. “What keeps the nurses interested in performing the test is that the patients are incredibly grateful for this service.”

But like the other trials, Highland Hospital’s experience illustrates roadblocks other EDs may face as they implement routine testing. The hospital offered the test to 31,342 patients in the first year of the ED testing program, and 16,547—more than half—agreed to be tested. But in the end, only 39%, or 6,368, of those who wanted to be tested actually were tested. Because nurses’ time ran short, translators could not be located, or the patient’s mental status changed so dramatically in the hours between the triage desk where the test is offered and the bedside encounter where the test is performed as to make consent impossible. And when White’s grant funding ran out recently, he faced ending the testing program because the county could not afford to pick up the cost—until a second grant came his way.

“My goal ultimately is for EDs, especially urban EDs like ours, to be recognized by the state Office of AIDS programs as testing centers that should receive state funding,” said White, who is Highland’s director of education and has a clinical appointment at University of California-San Francisco. “I think that is several years away.”

EMERGENCY MEDICINE’S MISSION

White plans to participate in a February workshop the CDC will hold in Los Angeles for hospitals in Western states, the first step in a nationwide teaching tour that emergency physicians say is badly needed. Departments who have implemented testing, including Couture’s and White’s, struggle with the time demands it imposes—though Couture finds that complaint beside the point.

“What is emergency medicine’s mission?” she asked. “It is saving lives. What is HIV? It’s an infectious disease emergency. You can say we are busy, but what are we supposed to be busy doing? We are supposed to be busy saving lives.”

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